STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E445	A. BUILDING _____ B. WING _____	07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	700 WILLIAMS FERRY RD LENOIR CITY, TN 37771

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual Recertification survey and investigation of complaint # 40402 conducted 7/17/17 - 7/19/17, at Baptist Health Care Center, no deficiencies were cited related to the complaint under CFR 483, Requirements for Long Term Care Facilities.	F 000	F 272: **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #53's functional status was re-assessed on 8/8/17 and a corrected MDS was completed on 8/9/17 to reflect resident's appropriate functional status. **How the facility will identify other Residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. 100% of all resident's current activities of daily living functional status will be audited by the Minimum Data Set Nurse or designee (Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator) by 8/17/17 to ensure residents activities of daily living functional statuses are coded correctly and reflected appropriately on the Certified Nursing Assistants Care Guides.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa A. Franklin | TITLE: Administrator | (X6) DATE: 8/11/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on review of the Centers for Medicaid and Medicare Services (CMS) Resident Assessment Instrument (RAI) Manual, review of facility policy, medical record review, observation, and interview, the facility failed to ensure the functional status of residents regarding their activities of daily living (ADLs) was comprehensively assessed for one resident (#53) of three residents reviewed for ADLs, of 22 residents sampled. The findings included: Review of CMS RAI Version 3.0 Manual for Section G0110: Activities of Daily Living (ADL) Assistance revealed the section entitled Coding Instructions stated, "for each ADL activity, consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look back period, as a resident's ADL	F 272	**What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.** The Minimum Data Set Nurse was in-serviced by the Director of Nursing on 8/8/17 on the Activities of Daily Living (ADL) Assistance policy which addresses that all episodes of the activity that occur over a 24-hour period during each day of the 7 day look back period, as a resident's activities of daily living self-performance and the support required may vary from day to day, shift to shift, or within shifts and the responsibility of the person completing the assessment therefore is to capture the total picture of the 7-day period, 24 hours a day encompassing all shifts. The Activities of Daily Living policy was also updated on 8/7/17 by the Director of Nursing to reflect that the documentation utilized to complete the Minimum Data Set Assessments will not be shredded. The Director of Nursing or designee (Assistant Director of Nursing, Nursing Supervisors, or Staff Development Coordinator) will in-service all Certified Nursing Assistants and licensed nurses on the new Activities	

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F 272	Continued From page 2 self-performance and support required may vary from day to day, shift to shift, or within shifts." The documentation further stated "Code 3, extensive assistance: if resident performed part of the activity over the last 7 days and help of the following type(s) was provided three or more times: weight bearing support provided three or more times, or full staff performance of activity three or more times during part but not all of the last 7days. Code 4, total dependence: if there was full staff performance of an activity with no participation by resident for any aspect of the ADL activity and the activity occurred three or more times. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period." Review of the facility policy and procedure "Activities of Daily Living (ADL) Assistance" dated October 2016, revealed, "...Coding Instructions for each ADL activity: Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period, as a resident's ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts...The responsibility of the person completing the assessment therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well..." Medical record review revealed Resident #53 was admitted to the facility on 12/14/16 with diagnoses including General Anxiety, Type 2 Diabetes, Spinal Stenosis, Schizophreniform Disorder, and Chronic Kidney Disease.	F 272	of Daily Living Flow Record which captures the resident's self - performance along with the support provided for all shifts by 8/17/17. New hire staff will be in-serviced during their orientation period. The Director of Nursing, Assistant Director of Nursing, or Minimum Data Set Nurse will audit 10 random Minimum Data Set Assessments monthly x 4 months to ensure activities of daily living are coded correctly. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** The Administrator or Director of Nursing will report findings of the Minimum Data Set Audit to the monthly Quality Assurance Performance Improvement Committee (members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical	

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F 272	Continued From page 3 Medical record review of Resident #53's quarterly Minimum Data Set (MDS) assessment dated 3/29/17 revealed the resident was assessed to require extensive assistance of two staff for dressing. Medical record review of the resident's quarterly MDS assessment dated 6/29/17 revealed the resident was assessed as totally dependent on two staff for dressing. Medical record review of Resident #53's current plan of care revealed the resident was identified to have an ADL self-care performance deficit related to impaired balance. The care plan interventions included an intervention for dressing that stated the resident needed extensive assistance of two caregivers as she could be combative with care. Medical record review of Resident #53's cumulative "Progress Notes" dated from 3/17/17 through 6/21/17 revealed no documentation of the resident having a change in her ADL functional status from extensive to totally dependent from March 2017 through June 2017. Interview with Certified Nursing Assistant (CNA) #1 on 7/19/17 at 8:10 AM, on the A unit hallway outside Resident #53's room, revealed she was assigned to provide care for the resident that day and had dressed the resident that morning. CNA #1 stated Resident #53 was totally dependent on staff for dressing and she was unaware of the resident having had any change in her dressing care needs over the last several months. Interview with Licensed Practical Nurse (LPN) #1 on 7/18/17 at 4:19 PM, and on 7/19/17 at 8:48	F 272	Records Director.) x 4 months for further suggestions and/or follow up as needed. Any aberrancies noted will be followed up on with appropriate interventions put in place. **Date of compliance: 8/17/17**	

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F 272	Continued From page 4 AM, in the assessment office, revealed she was the MDS assessment nurse. LPN #1 was asked where she gets the information for MDS coding for ADL function, she stated, "I get the information from the staff, and I have a form that I put that information on, then I put it into the MDS for that seven-day period." When asked if she has the forms that she collects the ADL information from staff, she confirmed that she does not keep those forms. LPN #1 shared a blank copy of the untitled and undated document and identified it as the document she used to gather resident information to code the MDS. LPN #1 stated after she coded the MDS she shredded the documents and did not have any documented evidence to show how she obtained information to code the resident's ADL function. When asked for daily documentation that includes all ADL documentation required for MDS Section G for functional status, she confirmed the facility documentation does not include those items and that it should. Interview with the Director of Nursing (DON) and Administrator on 7/19/17 at 8:59 AM, in the administrator's office, confirmed the facility's daily "ADL Documentation" does not include the required MDS information for section G for functional status. They stated it should present for accurate MDS coding. Interview confirmed the MDS nurse should be doing assessments for MDS information, along with using daily ADL information from the staff.	F 272	**F 282:** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #37's fall assessment was completed on 8/9/17 by licensed nursing personnel. Fall care plan was reviewed and updated on 8/9/17 with individualized interventions to prevent further falls. The Minimum Data Set Coordinator was responsible for completing the update. **How the facility will identify other Residents having the potential to be affected by the same deficient practice.** New fall assessments on all residents was initiated on 8/9/17 by licensed nursing personnel and will be	
F 282 SS=G	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 282		

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F 282	Continued From page 5 as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility records, review of emergency room records, observation, and interview, the facility failed to implement the falls care plan to prevent falls for 1 resident (#37) of 22 residents reviewed, resulting in a fall with a fracture and laceration requiring staples (Harm). The findings included: Medical record review revealed Resident #37 was admitted to the facility on 10/31/13 with diagnoses including Vascular Dementia with Psychosis, Heart Failure, and Kyphosis (deformity of the neck portion of the spine). Medical record review of the Minimum Data Set (MDS) dated 3/8/17 revealed a score of 1 on the Brief Interview for Mental Status, indicating severe impairment in cognitive function. Further review revealed the resident "sometimes understands" and required limited assistance of one person to transfer. Review of the 4 MDS assessments from 6/8/16-3/8/17 revealed no change in cognitive function or assistance required for transfer. Medical record review of the current care plan initiated 3/3/15 revealed, "...Focus...Resident remains at risk for falls r/t [related to] hx [history] of falls with hx rib fx [fracture]/pelvic fx....Floor	F 282	completed by 8-17-17 to identify those residents at risk for falls. The Interdisciplinary Team (Administrator, Nursing Director, Minimum Data Set Nurse, Rehabilitation Director, Social Worker, Staff Development Coordinator, Dietary Manager, Activity Manager, and Nursing Supervisor) will meet and review current interventions in place and determine appropriateness. This was initiated on 8/8/17. The Minimum Data Set Coordinator will be responsible for completing the update, if applicable, on all residents by 8-17-17. Care Plan and Care Guide audit was initiated on 8/8/17 and will be completed by 8-17-17 by licensed nursing personnel to ensure care interventions correctly reflect care to be delivered by Certified Nursing Assistants. The Interdisciplinary Team will review each resident incident within 72 hours to ensure that appropriate interventions, investigations, notification, and plan of care is in place on the Fall Care Plan Log. This was initiated 8/8/17.	

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F 282	Continued From page 6 mat Date Initiated: 07/13/2016...Place a contour mattress on her bed Date Initiated: 09/26/2016...Pressure pad alarm while in bed and chair at all times. Date Initiated: 07/12/2016...Regular bed- ½ side rails up X2 [two side rails] for mobility. Date Initiated: 03/03/2015...Scoot Chair for mobility as needed. Date Initiated: 03/03/2015... Transfers to chair with staff to prevent falls. Limited assist and one caregiver Date Initiated: 07/12/2016..." Review of an incident note dated 1/10/17 at 2:46 PM, revealed, "Activities director was walking by the patient's room and saw the patient sitting on her floor mat next to her bed. The patient's bed alarm not going off..." Further review revealed the resident had no injuries. Review of the facility's investigation and interventions for the fall on 1/10/17 revealed, the facility did not address the care planned intervention of the safety alarm not sounding at the time of the fall. Review of an incident note dated 1/26/17 revealed, "...At approx. [approximately] 0935 [9:35 AM] alerted by [hospice] staff member that a resident was in the lobby on the floor and needed assistance. This nursed observed resident sitting upright in floor with her back against the couch in the lobby. Resident stated she slid right off the couch et [and] denies any pain..." Further review revealed the resident had no injuries. Medical record review of the resident's current care plan revealed, "...Try using a non skid pad under her buttocks to prevent sliding Date Initiated: 01/27/2017..."	F 282	**What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.** Certified Nursing Assistants and Licensed Nurses will be in-serviced by the Director of Nursing and/or designee (Assistant Director of Nursing, Staff Development Coordinator) on the Falls and Fall Risk Management Guidelines and the Fall Algorithm beginning 8/2/17 and will be completed by 8-17-17. The policy discusses that interventions should be individualized according to the resident's needs. Once a resident has been identified as being at risk for falling and interventions have been implemented to minimize the risk of falling, the information needs to be communicated in the resident's chart (care plan), on the care guides for Direct Care Staff, and in-servicing as appropriate. New staff will be in-serviced during their orientation period. Staff that have missed in-servicing will not be able to work 8-17-17 or after until in-serviced. The Director of Nursing, Assistant Director of Nursing, Nursing Supervisor, or Staff Development Coordinator will audit 20 random residents who are at risk for falls	

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F 282	Continued From page 7 Medical record review of an incident note dated 2/6/17 at 3:16 PM, revealed, "...alerted this nurse to resident's room. As entering room, this nurse bserved [observed] resident sitting upright in the floor next to foot board of bed. Resident stated she did not hit her head, voices 0 c/0 [no complaints] et denies any pain..." Further review revealed the resident had no injury. Review of the facility's investigation and interventions for the fall on 2/6/17 revealed, "...Spoke with...NP...who will be at facility on 2/7/17 and will eval [evaluate] residents's [resident's] meds [medications]. Will continue to have all safety devices in use at all times..." Further review revealed no indication if the care planned interventions of the alarm and non skid pad was in place and functioning to prevent the fall. Review of an incident note dated 2/13/17 at 12:30 AM, revealed, "...nursing assistants assisted resident to bed and immediately after leaving room heard a thud followed by the bed alarm. This nurse immediately responded and observed resident lying on floor just passed floor mat with a two CM [centimeter] open are [area] on forehead with a red substance dripping, also a red substance from nose and an ecchymosis [bruising] on Left knee...Agreed to send to ER [Emergency Room]...Resident left via ambulance at @ 0045..." Review of the emergency department record for the local hospital revealed Resident #37 was admitted at 53 minutes after midnight on 2/13/17 and the Discharge Summary, dated 2/13/17 at 2:55 AM, revealed "...Injury to...left knee and	F 282	3x/week x 4 weeks, then weekly x 4 weeks, then monthly ongoing to ensure fall interventions are in place, care plan and Certified Nursing Assistant Care Guides are updated to prevent further falls. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** The Director of Nursing or Assistant Director of Nursing will report findings of the Fall Audit to the monthly Quality Assurance Performance Improvement Committee (members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) ongoing for further suggestions and/or follow up as needed. Any aberrancies noted will be followed up on with appropriate interventions put in place. **Date of Compliance: 8-17-17**	

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F 282	Continued From page 8 upper portion of face; Multiple abrasions affecting...left knee and upper portion of face...Laceration of forehead (closed with staples); Closed fracture of sixth cervical [neck] vertebra..." Observation of the resident on 7/18/17 at 9:30 AM, with Licensed Practical Nurse (LPN) #2, in the resident's room, revealed the resident was in a normal height bed positioned against the wall, unable to be seen until the room was entered. Observation of the resident's "Scoot chair" revealed the seat did not have a nonskid pad. Interview with LPN #2 on 7/18/17 at 9:30 AM, in the resident's room, revealed she was unaware the resident's chair was care planned for a nonskid pad. Interview continued and the LPN stated the Certified Nurse Aides "can look at the care plan in the front of the chart" for the resident's fall interventions. Interview with the Director of Nurses (DON) on 7/19/17 at 1:25 PM, in the conference room, confirmed the facility staff had not investigated each fall and did not develop interventions to address the circumstances of each fall. Interview confirmed the resident sustained a cervical neck fracture on 2/13/17. The DON stated, "...interventions weren't always put into place to address falls..." Refer to F-323	F 282	**F 323:** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #37's fall assessment was completed on 8/9/17 by licensed nursing personnel. Fall care plan was reviewed and updated on 8/9/17 with individualized interventions to prevent further falls. The Minimum Data Set Coordinator was responsible for completing the update. Resident #37 was also assessed for bed rail usage on 8/9/17. Resident #37 will be reassessed quarterly for continued bed rail usage. Resident #'s 3, 6, 16, 63, 1, and 53's water temperatures now fall within acceptable parameters of 105 -115 degrees Fahrenheit. The Maintenance Director reduced the temperature on the hot water heater on 7-18-17 once issue was noted.	
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		

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F 323	Continued From page 9 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility records, review of emergency room records, observation, interview, and review of facility policy, the facility failed to provide adequate supervision to prevent falls for 1 resident (#37) of 22 residents reviewed, resulting in a fall with a cervical fracture and laceration requiring staples (Harm); and the facility failed to maintain hot water temperatures within safe parameters to prevent burns for 6 residents (#3, #6, #16, #63, #1 and #53) of 22 residents reviewed. The findings included:	F 323	**How the facility will identify other Residents having the potential to be affected by the same deficient practice.** New fall assessments on all residents was initiated on 8/9/17 by licensed nursing personnel and will be completed by 8-17-17 to identify those residents at risk for falls. The Interdisciplinary Team (Administrator, Nursing Director, Minimum Data Set Nurse, Rehabilitation Director, Social Worker, Staff Development Coordinator, Dietary Manager, Activity Manager, and Nursing Supervisor) will meet and review current interventions in place and determine appropriateness. This was initiated on 8/9/17. The Minimum Data Set Coordinator will be responsible for completing the update, if applicable, on all residents by 8-17-17. Care Plan and Care Guide audit was initiated on 8/9/17 and will be completed by 8-17-17 by licensed nursing personnel to ensure care interventions correctly reflect care to	

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F 323	Continued From page 10 Medical record review revealed Resident #37 was admitted to the facility on 10/31/13 with diagnoses including Vascular Dementia with Psychosis, Heart Failure, and Kyphosis (deformity of the neck portion of the spine). Medical record review of the Minimum Data Set (MDS) dated 3/8/17 revealed a score of 1 on the Brief Interview for Mental Status, indicating severe impairment in cognitive function. Further review revealed the resident "sometimes understands" and required limited assistance of one person to transfer. Review of the 4 MDS assessments from 6/8/16-3/8/17 revealed no change in cognitive function or assistance required for transfer. Medical record review of the current care plan initiated 3/3/15 revealed, "...Focus...Resident remains at risk for falls r/t [related to] hx [history] of falls with hx rib fx [fracture]/pelvic fx...Floor mat Date Initiated: 07/13/2016...Place a contour mattress on her bed Date Initiated: 09/26/2016...Pressure pad alarm while in bed and chair at all times. Date Initiated: 07/12/2016...Regular bed- ½ side rails up X2 [two side rails] for mobility. Date Initiated: 03/03/2015...Scoot Chair for mobility as needed. Date Initiated: 03/03/2015...Transfers to chair with staff to prevent falls. Limited assist and one caregiver Date Initiated: 07/12/2016..." Medical record review of the Interdisciplinary Progress Notes revealed the resident had 5 falls from August-November 2016 and was transferred to a gero-psych unit in December 2016 in an attempt to develop an improved therapeutic medication regime to address Anxiety, Insomnia, Dementia with related Psychosis, and was	F 323	be delivered by Certified Nursing Assistants. The Interdisciplinary Team will review each resident incident within 72 hours to ensure that appropriate interventions investigations, notification, and plan of care is in place on the Fall Care Plan Log. This was initiated 8/9/17. All residents with bed rails will be screened for appropriateness by 8/17/17 by the Director of Nursing, Assistant Director of Nursing, Nursing Supervisors, or Staff Development Coordinator. Side rails will be removed for those residents in which side rails are not appropriate. For those residents who are expressing a desire to have bedrails, an order will be obtained by the attending physician, consent obtained by the resident and/or responsible party, an assessment completed for side rail screening to ensure appropriateness, and a care plan developed indicating the need for the side rails. Attempt to reduce the usage for side rails will be made on a quarterly basis. The Maintenance Director reduced the temperature on the hot water heater that was responsible for the elevated temps on 7/19/17. The Preventative Maintenance Sheet was updated on	

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F 323	Continued From page 11 returned to the nursing home on 12/16/16. Medical record review of the Psychiatric Nurse Practitioner's progress notes revealed on 12/20/16, "...staff notes pt [patient] still anxiously inconsolable post gpsych [geropsych] visit...Very HOH [hard of hearing]..." and on 1/10/17, "...Insight poor Judgement poor Impulse control poor Orientation x1 [to self] Memory poor...Mood anxious/inconsolable. Affect worried..." Review of an incident note dated 1/10/17 at 2:46 PM, revealed, "Activities director was walking by the patient's room and saw the patient sitting on her floor mat next to her bed. The patient's bed alarm not going off..." Further review revealed the resident had no injuries. Review of the facility's investigation and interventions for the fall on 1/10/17 revealed, "...Resident seen today by...NP [Nurse Practitioner]...and an extra dose of Xanax [antianxiety] was ordered and administered. NP notified of incident following administration and nurse will continue to monitor hours of sleep on shifts to determine actual amount of sleep resident is getting. Safety measures in place and proper working order..." Further review revealed the facility did not address the safety alarm not sounding at the time of the fall. Review of an incident note dated 1/26/17 revealed, "...At approx. [approximately] 0935 [9:35 AM] alerted by [hospice] staff member that a resident was in the lobby on the floor and needed assistance. This nursed observed resident sitting upright in floor with her back against the couch in the lobby. Resident stated she slid right off the couch et [and] denies any	F 323	7/19/17 to include testing water temps on resident sinks. **What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.** Certified Nursing Assistants and Licensed Nurses will be in-serviced by the Director of Nursing and/or designee (Assistant Director of Nursing, Staff Development Coordinator) on the Fall and Fall Risk Management Guidelines and the Fall Algorithm beginning 8/2/17 and will be completed by 8-17-17. The policy discusses that interventions should be individualized, according to the resident's needs. Once a resident has been identified as being at risk for falling and interventions have been implemented to minimize the risk of falling, the information needs to be communicated in the resident's chart (care plan), on the care guides for Direct Care Staff, and in-servicing as appropriate. New staff will be in-serviced during their orientation period. Staff that have missed in-servicing will not be able to work 8-17-17 or after until in-serviced. The Director of Nursing, Assistant Director of Nursing, Nursing	

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F 323	Continued From page 12 pain..." Further review revealed the resident had no injuries. Review of the facility's investigation and interventions for the fall on 1/26/17 revealed adjustments to the resident's medications were made prior to the fall on 1/26/17. Adjustments were to Klonopin (benzodiazepine) and Zyprexa (antipsychotic) on 1/18/17, and to Zyprexa again on 1/24/17. After the fall the facility requested the Psychiatric Nurse Practitioner to review medications and no adjustments were made. Medical record review of the resident's current care plan revealed, "...Try using a non skid pad under her buttocks to prevent sliding Date Initiated: 01/27/2017..." Medical record review of an incident note dated 2/6/17 at 3:16 PM, revealed, "...alerted this nurse to resident's room. As entering room, this nurse bserved [observed] resident sitting upright in the floor next to foot board of bed. Resident stated she did not hit her head, voices 0 c/0 [no complaints] et denies any pain..." Further review revealed the resident had no injury. Review of the facility's investigation and interventions for the fall on 2/6/17 revealed, "...Spoke with...NP...who will be at facility on 2/7/17 and will eval [evaluate] residents's [resident's] meds [medications]. Will continue to have all safety devices in use at all times..." Further review revealed no indication if the alarm or non skid pad was in place and functioning to prevent the fall. Review revealed medication adjustments were made to the resident's Zyprexa, Buspar (antidepressant), Klonopin, and Temazepam (benzodiazepine).	F 323	Supervisor, or Staff Development Coordinator will audit 20 random residents who are at risk for falls 3x/week x 4 weeks, then weekly x 4 weeks, then monthly ongoing to ensure fall interventions are in place, care plan and Certified Nursing Assistant Care Guides are updated to prevent further falls. The Director of Nursing, Minimum Data Set Nurse, Assistant Director of Nursing, Staff Development Coordinator, or Nursing Supervisors will audit all residents with side rails quarterly to ensure residents with side rails remain appropriate for side rails and ensure consents and orders for side rails are present in the resident's chart. The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will in-service all licensed nurses on the Side Rail Policy by 8-17-17. All new hires will be in-serviced during their orientation period. The Maintenance Director will conduct temperature tests on the front, middle, and back of E and F wings (where the temps were out of range) 5x/week x 4 weeks, then weekly x 4 weeks, then monthly ongoing. This was initiated on 7/19/17. A, B, C, and D wings will also have temperature	

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F 323	Continued From page 13 Medical record review of the Psychiatric Nurse Practitioner's progress notes dated 2/7/17 revealed, "Staff notes pt takes Klonopin at around 7-8pm sleeps and then wakes around midnight, they give prn [as needed] dose and sometimes she sleeps and sometimes she doesn't. Persistent insomnia recently..." Review of a nursing progress note dated 2/12/17 at 6:15 AM, revealed, "Resident has been awake all night, seeking attention, has been to bed multiple times but would not stay, denies pain or discomfort..." Review of an incident note dated 2/13/17 at 12:30 AM, revealed, "...nursing assistants assisted resident to bed and immediately after leaving room heard a thud followed by the bed alarm. This nurse immediately responded and observed resident lying on floor just passed floor mat with a two CM [centimeter] open are [area] on forehead with a red substance dripping, also a red substance from nose and an ecchymosis [bruising] on Left knee...Agreed to send to ER [Emergency Room]...Resident left via ambulance at @ 0045..." Review of the emergency department record for the local hospital revealed Resident #37 was admitted at 53 minutes after midnight on 2/13/17 and the Discharge Summary, dated 2/13/17 at 2:55 AM, revealed "...Injury to...left knee and upper portion of face; Multiple abrasions affecting...left knee and upper portion of face...Laceration of forehead (closed with staples); Closed fracture of sixth cervical [neck] vertebra...transfer to another hospital...Trauma..."	F 323	checks monthly on front, middle, and back of wings ongoing to include resident sinks. A, B, C, and D wings had no issues with temperatures during survey. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** The Director of Nursing or Assistant Director of Nursing will report findings of the side rail audit and fall audit to the monthly Quality Assurance Performance Improvement Committee (members include: Committee Chairperson - Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) ongoing for further suggestions and/or follow up as needed. The Maintenance Director will report findings of the temperature audits to the monthly Quality Assurance Performance Improvement meeting monthly	

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F 323	Continued From page 14 Review of the Neurosurgery Consult dated 2/13/17 at 7:41 AM, at the Trauma hospital, revealed a vertebral artery injury had been ruled out, "...the C6 arterio-tubercle is not involved in the stability of the C [cervical/neck] spine and therefore does not require any treatment..." Further review revealed the resident was transferred back to the nursing home at 10:04 AM on 2/13/17. Review of the facility's investigation and interventions for the fall on 2/13/17 revealed, "...Call placed to...NP...for med adjustment to promote nighttime sleep/rest for resident. Haloperidol [antipsychotic] dosage adjustment made..." Observation of the resident on 7/18/17 at 9:30 AM, with Licensed Practical Nurse (LPN) #2, in the resident's room, revealed the resident was in a normal height bed positioned against the wall, unable to be seen until the room was entered. Observation of the resident's "Scoot chair" revealed the seat did not have a nonskid pad. Interview with LPN #2 on 7/18/17 at 9:30 AM, in the resident's room, confirmed there was not a nonskid pad present and she was unaware the resident's chair was to have a nonskid pad. Interview with the Director of Nurses (DON) on 7/19/17 at 1:25 PM, in the conference room, confirmed the facility staff had not investigated each fall and did not develop interventions to address the circumstances of each fall, prior to the 2/13/17 fall with fracture. Interview confirmed the resident sustained significant trauma and a cervical neck fracture on 2/13/17. The DON stated, "I can only answer for what has happened	F 323	ongoing for further suggestions and/or follow up as needed. Any aberrancies noted will be followed up on with appropriate interventions put in place. **Date of Compliance: 8-17-17**	8/17/17

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F 323	Continued From page 15 since I came in April of this year...the staff did not know how to do a root cause investigation...interventions weren't always put into place to address falls..." Review of policy and procedure "Standards for Nursing Homes" dated March 2014, received on 7/19/17 at 10:50 AM from Maintenance Staff #2, revealed, "...Hot water at shower, bathing and hand washing facilities shall be between 105 degrees F (Fahrenheit) and 115 degrees F." On 7/17/17 at 10:35 AM, observations were made of resident rooms and hot water temperatures were measured. The hot water temperatures were 120 degrees Fahrenheit (F) in the bathrooms of Resident #3, #6, #16, and #63. On 7/17/17 at 11:08 AM, an interview and observation with Maintenance Staff #1 was made in the rooms of Resident #1 and #53. Maintenance Staff #1 obtained a hot water temperature in the sink of Resident #1 and #53. He verified the hot water temperature was 120 degrees F. He verified hot water temperatures should be between 105 and 115 degrees F.	F 323		